

# PIC *Highlights*

Volume 9, No. 1

Spring 1999

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## Meeting the Challenge of Serving People with Disabilities: A Resource Guide for Assessing the Performance of Managed Care Organizations

In 1991 and 1992, there were 48.9 million Americans with a disability, or nearly 19.4 percent of the total U.S. population. At that time, approximately 19 percent of persons with disabilities aged 15 to 64 were covered by Medicaid. In 1995, according to the Health Care Financing Administration (HCFA), approximately six million people with disabilities were covered by Medicaid, of whom 1.3 million were children. Within Medicaid, those with Supplemental Security Income (SSI) were the second fastest growing eligibility group between 1990 and 1994, increasing at an average annual rate of 10 percent. In 1995, the disabled accounted for 15 percent of all Medicaid users, while their spending accounted for 39 percent of all program payments.

Due to a lack of comprehensive performance measurement standards, this report, *Meeting the Challenge of Serving People with Disabilities: A Resource Guide for Assessing the Performance of Managed Care Organizations*, was designed to support efforts to measure and improve Medicaid Managed Care Organization (MCO) performance for people with disabilities. The Resource Guide represents the results of an extensive search for existing performance measures that can be used for quality measurement and improvement by State Medicaid agencies, MCOs, providers within MCOs and health care advocates for the disabled

population. Its purpose is to present an overview of the issues to be considered in measuring the performance of MCOs in taking care of people with disabilities, provide information about measures that now exist, or are about to be made available, that can be counted on to support efforts to measure and improve the care provided by MCOs to people with disabilities, and to make clear the areas where technically strong measures do not exist, in order to encourage further measurement development in these areas.

Several States have now begun to implement, or seriously consider, the use of managed care for people covered by Medicaid because they are eligible for SSI; all eligibles in this category are by definition persons with a disability. As more disabled people covered by Medicaid enroll in MCOs, concerns arise about whether MCOs can and will meet the special health care needs of this population. Many people with disabilities require a complex mix of health and social services to maintain health and functioning, including coordinated physical and behavioral health care, episodic curative care, ongoing care, and access to specialized providers, medications, supplies and equipment. For that reason, it is becoming increasingly critical to determine whether MCOs are performing well in meeting the needs of the disabled.

The expansion of managed care has been accompanied by increased attention to performance measurement for health care delivery systems, and an increased emphasis on the need to hold systems accountable for their performance. One advantage of the MCO is that it is easier to measure, and thus to improve, the performance of a given system. While MCOs may be easier to evaluate, comprehensive systems for measuring the performance of health care systems in caring for persons with disabilities are not yet available. Thousands of individual quality measures exist, but it is often difficult to discern which will be most reliable and relevant to measure MCO performance in caring for people with disabilities. This Resource Guide provides managed care performance measure indicators, and aims to improve Medicaid MCO performance for those with disabilities.

This study was conducted by George Washington University, under contract with the Office of the Assistant Secretary for Planning and Evaluation. The project officer, Gavin Kennedy, can be reached at 202-690-6443. Copies of the executive summary #6753, are available from the PIC.

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## Effective Practices of Foster Grandparents in Head Start Centers: Benefits for Children, Classrooms and Centers

The Foster Grandparent Program offers opportunities for income-eligible people age 60 and older to provide ongoing supportive services in health, education, welfare and related settings to children and youth with exceptional or special needs. Nationwide, there are more than 25,000 Foster Grandparents serving nearly 90,000 exceptional children on an ongoing basis. Ninety percent of Foster Grandparents are female, and half are in their 70s. Most volunteers serve in public or private school settings or day care centers, and approximately 4,000 Foster Grandparents (16 percent) serve in Head Start.

***Effective Practices of Foster Grandparents in Head Start Centers: Benefits for Children, Classrooms and Centers*** focused on what Foster Grandparents do in Head Start programs, and how their contributions benefit the children they serve. It aimed to increase knowledge about the roles of Foster Grandparents in Head Start stations, examine the effects that the program may have on children, and identify practices that either help or hinder Foster Grandparent contributions to positive results for children.

Six Foster Grandparent projects with volunteers serving in Head Start centers were selected from five cluster areas of the U.S., including both urban and rural populations. Six classrooms, one from each site, and their respective Foster Grandparents were the main focus of the study. In each of the six study sites, a site visitor team observed one

study classroom of children ages 4 to 5 for approximately four hours in order to learn what the Foster Grandparents did and how their actions and behaviors may have contributed to positive child outcomes. Each observer took detailed notes describing the number and characteristics of the children and adults present in the classroom, the physical layout of the room, the schedule of activities, what the Foster Grandparents did, the nature and quality of their interactions with the children, and how the children responded to the Foster Grandparents. The Arnett Scale of Caregiver Behaviors, which measures the caregiving behavior of individual adults in a classroom, was used to provide consistency in reporting across sites. Behaviors on the scale are associated with positive development and outcomes for children. At the end of the observation, site visit team members met for two to three hours to discuss observations and impressions.

Findings from the study indicated that the majority of Foster Grandparents engaged in a wide range of activities and interactions that contributed positively to children, classrooms and stations. These behaviors are described by 14 items on the Arnett Scale. For this study, these caregiving behaviors were organized into three general categories: (1) engaging in positive one-on-one interactions with children, (2) developing or reinforcing pro-social behaviors, and (3) providing children with constructive guidance and feedback. A sizable body of evidence indicates that such caregiver behaviors are associated with positive developmental outcomes for children. Accordingly, Foster Grandparents provided support to the children in five outcome areas involving emotional well-being, self-esteem, social skills, language development and cognitive development. Contributions observed from the Foster Grandparents' service at the classroom and station levels included increased opportunities for all children in the classroom to receive individualized adult attention, a calming influence on the classroom environment, behind-the-scenes support facilitating smooth transitions from one activity to the next, and continuity for children when teaching staff were absent. Overall, the presence and activities of the Foster Grandparents benefitted the children

both directly, through interaction, reinforcement and guidance, and indirectly, through teacher assistance and classroom continuity.

This study was conducted by Westat, Inc., under contract with the Corporation for National and Community Services (CNCS). Copies of the executive summary #7109 are available from the PIC.

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## Strategies for the Recruitment, Retention and Graduation of Hispanics into the Baccalaureate Level of Nursing

Hispanics are the youngest and one of the fastest-growing ethnic populations in the United States, projected to comprise 11 percent of the U.S. population by the year 2000. The Health Resources and Services Administration's (HRSA's) mission to assure that quality health care is available to underserved and vulnerable populations includes a mandate to increase the number of health care providers from racial and ethnic minority backgrounds. Healthy People 2000 objectives for the Nation specify an increase in the proportion of all degrees in the health professions and allied and associated health professional fields awarded to minorities, from the 1985-1986 baseline of three percent, to 6.4 percent by the year 2000.

Although nurses make up the largest segment of the Nation's health care providers, recent data suggest that fewer than two percent of the 2.5 million Americans with current licenses to practice as registered nurses in March of 1996 were of Hispanic background. Over half of these Hispanic individuals entered nursing through associate degree programs, as compared to a little over a third of all nurses of all ethnic groups. Also, more recent Hispanic graduates were more likely to hold an associate degree rather than a baccalaureate degree, and Hispanic nurses were less likely than either black or white nurses to hold

advanced (master or doctoral) degrees. Only very slight gains in the admission of Hispanic students into nursing schools have been made since 1972, when the National League for Nursing first began collecting ethnic classification data. The admission rate for Hispanic nursing baccalaureate students has almost consistently remained below three percent.

As part of the national effort to achieve the Healthy People 2000 goal, the HRSA Division of Nursing conducted a study entitled ***Strategies for the Recruitment, Retention and Graduation of Hispanics into Baccalaureate Levels of Nursing***. Based on the research, this study developed a model that can be used as a conceptual framework by Institutions of Higher Education (IHE) seeking to increase the proportion of Hispanic Americans admitted to baccalaureate programs as their initial entry into nursing education. The model explicates promising strategies for the recruitment of Hispanics into baccalaureate nursing programs, along with approaches to address retention and graduation difficulties. It also suggests implementation issues that may arise when these strategies are put into practice.

Two main sources of data collection were employed, the first being a search and review of available literature concerning the recruitment, retention and graduation of Hispanics into baccalaureate nursing programs. The second source of data consisted of site visits to eight schools of nursing, and included in-depth interviews with students, faculty, student services personnel and administrators. The site visit data collection was guided by, and built upon, the results of the literature search and review.

Overall, findings indicated that financial aid issues are important to Hispanic students. Academic support and retention issues included little or no contact with academic services and extracurricular activities, few Hispanic faculty and role models, ignorance of student academic needs, inflexible academic schedules, and inadequate cultural content in the curriculum. Overall, the research indicated that there is a general lack of attention to recruitment of Hispanic students into nursing programs.

Recruitment of Hispanic students into nursing appears to be facilitated when institutions engage in proactive outreach to Hispanic high school students, and focus efforts in health career magnet programs and math and science honors programs. Furthermore, retention and graduation of Hispanic Bachelor of Science in Nursing (BSN) students appears to be improved when institutions offer specialized orientation programs to acculturate Hispanics to campus life, involve Hispanic parents early in the academic process, and provide a student services specialist skilled in Hispanic socio-cultural issues. Institutions also need to provide coping, study and life skills classes, insure the availability, accessibility and student awareness of co-curricular services, provide assistance to students in securing financial aid, adopt a student-centered approach to instruction, offer flexibility in class scheduling and course loads, provide Hispanic faculty/clinical role models, and emphasize Hispanic content relating to the provision of culturally appropriate nursing care.

The study recommended that the IHE, in cooperation with Federal agencies, schools, professional associations and members of the private sector, work together in order to provide opportunity and assistance to promote Hispanic minority nursing education.

This study was conducted by CDM Group, Inc., under contract with the Health Resources and Services Administration. The project officer, Ernell Spratley, can be reached at 301-443-3680. Copies of the executive summary #6249 are available from the PIC.



## Strategies for Obtaining Public Health Infrastructure Data at Federal, State and Local Levels

Legislative reforms and dynamic market forces have affected health services financing, delivery and regulation, obscuring the lines between personal health care and public health services. Amidst all this change, policymakers have called for increased accountability and efficiency from both public and private health care providers. Given these trends, the public health community has begun to re-evaluate its role in the health care system, questioning whether the existing public health infrastructure adequately supports these evolving responsibilities.

Public health professionals have struggled to keep abreast of changes in a rapidly evolving health care environment. They have been faced with questions such as: How should the responsibilities of public health change to reflect changes in the health care market? What unique role should public health play, given existing needs, resources and financial support? Are the services provided by the public health community appropriate? If not, how should they change over time? What impact are these services having? Should State and local health departments continue to provide direct personal health care services? What skills, knowledge and competencies will public health professionals need to adapt to these evolving responsibilities? What organizational competencies should public health agencies be developing and maintaining?

This study, *Strategies for Obtaining Public Health Infrastructure Data at Federal, State and Local Levels*, sought ways to obtain better public health infrastructure data at the Federal, State and local levels. The report summarized the proposed data strategy for collecting infrastructure-related information, assessed the information needs surrounding the public health infrastructure issue, identified and evaluated existing data sources, and developed alternative strategies for responding to identified “gaps” in available infrastructure-related data.

The roles and responsibilities of the public health infrastructure are well-defined, however policymakers, public health professionals and researchers currently do not have access to comprehensive information on the capacity and functioning of the public health system. Instead, recent public health research has focused almost exclusively on population health risks and resulting health outcomes. Little attention has been paid to examining how variations in the nature and strength of the public health infrastructure influence risks and outcomes. This type of information is crucial for evaluating the impact of market-based changes on public health services, examining the cost-effectiveness of public health interventions, and improving the performance of public health agencies. By developing a clearer picture of what public health services are currently being provided, by whom, with what staff and at what cost, the public health community can begin to fully assess the adequacy and performance of the existing infrastructure, and plan for necessary modifications.

The information needs assessment phase determined what information was needed to monitor the nature and adequacy of the public health infrastructure. This process utilized structured focus groups involving public health officials from all levels of government, as well as representatives of the research community, and one-on-one interviews with public health officials at State and local levels. The assessment of existing data sources identified current and historical efforts to characterize the public health infrastructure in the U.S., and to assess how well these efforts responded to user information needs. This assessment relied on literature reviews, interviews with experts knowledgeable about national infrastructure data collection activities, and interviews with State and local officials.

Based on the information needs assessment and an assessment of existing data sources, the strategy for obtaining infrastructure data consisted of national surveys, case studies and a research agenda. Each component of the data strategy was designed to support the other components, although each could have been independently pur-

sued. While this data strategy was not designed to resolve all the important challenges facing public health, it provided information for responding to those challenges through research.

The infrastructure data indicated that State and local officials sought models of well-run programs and effective public health interventions. Few existing data sources provided macro-level information summarizing the basic structure, capacity and functioning of public health organizations, and no single available data source provided a holistic profile of the public health system. Also, many existing sources were “one time only” studies that did not support long-term, periodic monitoring of the public health infrastructure.

Based upon the research and data, the following recommendations were made: (1) A lead agency should be assigned responsibility for data strategy implementation. (2) Federal staff representing the lead agency should be actively involved in data strategy implementation. (3) A steering committee, such as the Public Health Functions Steering Committee, should be designated to guide implementation of the data strategy. (4) Potential funding sources for the data strategy should be identified as soon as possible. (5) Data reporting by State and local public health agencies should be linked to funding streams. (6) Before implementation proceeds, the data strategy must be refined to reflect important, emerging national initiatives. (7) Implementation of the proposed strategy should integrate existing survey efforts sponsored by the National Association of County and City Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO) and the Public Health Foundation. (8) The feasibility of using the ten essential services as a data collection tool should be carefully considered. (9) Plans for information analysis and dissemination should be made prior to strategy implementation.

This proposed data collection strategy will provide an opportunity for the Federal government to take a leadership role in shaping the future of the public health infrastructure. Public health continues to face many challenges that are likely to have profound implications for the nature, scope

and structure of the essential services. The systematic approach for tracking changes in the public health infrastructure promises to identify optimal approaches to service delivery, establish performance standards for public health agencies, demonstrate the cost effectiveness of public health, identify areas in need of capacity development, and enable advocacy for appropriate resources. The effective implementation of this monitoring effort represents an important step in preparing public health for the 21<sup>st</sup> century.

This study was conducted by Lewin-VHI, Inc., under contract with the Office of the Assistant Secretary for Planning and Evaluation. The project officer, Jim Scanlon, can be reached at 202-690-7100. Copies of the executive summary #6179, are available from PIC.

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## Tobacco Retailer Study

Most smokers in America began smoking as teenagers. If smoking is curtailed and discouraged in the teen years, then the overall incidence of adult smoking (25 percent in 1994) will drop sharply over the next few generations. For this reason, the Food and Drug Administration (FDA) hopes to reduce access to, and appeal of, tobacco products to youth under age 18 through two recent FDA requirements. The first requirement states that retailers are prohibited from selling cigarettes and smokeless tobacco products to persons younger than age 18. The second mandates that retailers must verify, by means of photographic identification, the age of purchasers who are younger than age 27.

Through cooperation with an advertising agency, the FDA launched a media campaign targeted to tobacco retailers in nine States in June, 1998. The campaign aimed to raise awareness of the new regulations and to encourage compliance. This report, ***Tobacco Retailer Study***, summarizes reactions and major changes in awareness, knowledge and behaviors during the course of the campaign.

The media outlets that were utilized included radio, billboards, newspapers, outdoor posters, direct mail and media kits, and were targeted to retail stores (convenience stores, gas stations, grocery stores, liquor stores, general merchandise stores, pharmacies, drug stores, taverns and bars) and their owners, managers, clerks and cashiers and, secondarily, to customers. The distributed media kit included posters, countertop mats, table tents, fact sheets and peel-off door clings that emphasized the need for tobacco consumers to show identification. The unified campaign message stressed the need to check identification, and informed retailers regarding the law, fines and compliance checks. Pilot-tested in Arkansas in February, 1998, the campaign was later extended to nine other States. Each State had a test site and a control site, with compliance checks taking place both before and during the campaign. These compliance checks consisted of an underage youth and an adult accomplice attempting to purchase tobacco products. Although compliance checks were random and unannounced, stores in test and control sites were forewarned of this possibility in a letter from the FDA.

Results from the study indicated that, throughout the course of the campaign, awareness of advertising for the new rule grew from 47 percent to 67 percent in the test sites. Ad awareness in control sites that received no advertising increased by just four points, from 42 percent to 46 percent. Among the test sites, Denver and Chicago showed the most remarkable gains in awareness (30 points). Knowledge that all persons under the age of 27 must be carded rose dramatically, from 34 percent to 54 percent in test sites. In addition, the campaign appears to have cleared up misconceptions surrounding the potential consequences associated with retailer non-compliance. According to managers, sharing information about the FDA rule with clerks was nearly universal, and this was most

commonly accomplished through individual meetings.

Perhaps the greatest tribute to the campaign was the small but significant decline in the number of times minors tried to buy tobacco products. According to retailers, before the campaign, the average number of times minors attempted to buy tobacco was 3.4 times daily. After the media effort, this dropped to 2.8 times each day. In the control sites, the number of attempts to purchase did not change. Also, the frequency with which customers volunteered identification increased. Overall, claimed awareness of advertising about the "photo ID for minors" rule rose to 67 percent in test sites, up from 47 percent. Among all media outlets, radio emerged as the most powerful medium for the message.

The final report gives additional detailed information on the background and methods used, levels of awareness (both pre- and post-campaign), knowledge levels, communications about the laws, behaviors and reactions to the laws, characteristics of survey respondents, and the ad campaign structure and focus.

This study was conducted by Market Facts, Inc., under contract with the Food and Drug Administration. The project officer, Sharon Natanblut, can be reached at 301-827-3442. Copies of the executive summary #7079.1 are available from the PIC.

## RECENTLY ACQUIRED REPORTS

- ***The Health and Well-Being of Children in Immigrant Families***  
(PIC ID No. 6752)
- ***Indicators of Welfare Dependence: Annual Report to Congress October 1998***  
(PIC ID No. 6634.2)
- ***Evaluation of the Indian Health Service Adolescent Regional Treatment Centers, Volume I***  
(PIC ID No. 6744)
- ***The Implementation of Healthy Start: Lessons for the Future***  
(PIC ID No. 5610.1)
- ***Micro Business and Self-Employment and Programs for the Homeless***  
(PIC ID No. 6883)

## SERVICES AVAILABLE FROM THE PIC

The Policy Information Center (PIC) is a centralized source of information on in-process, completed, and on-going evaluations; short-term evaluative research; and policy-oriented projects conducted by HHS as well as other Federal departments and agencies. The PIC on-line database provides project descriptions of these studies. It is available on-line at: <http://aspe.os.dhhs.gov/PIC/gate2pic.htm>. Inquiries regarding PIC services should be directed to Carolyn Solomon, Technical Information Specialist, at 202-690-5694. Or E-mail PIC at: [pic@osaspe.dhhs.gov](mailto:pic@osaspe.dhhs.gov).

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